BLUE CROSS BLUE SHIELD OF MONTANA
MANAGED CARE PLAN SUPPLEMENT TO THE SUMMARY PLAN DOCUMENT

This Managed Care Plan Supplement replaces the following medical benefits sections of the Summary Plan Document for State Plan members enrolled in the managed care benefit plan administered by Blue Cross Blue Shield of Montana:

SECTION G (CHAPTER 2)

SECTION L (CHAPTER 3)

For purposes of this supplement, "health plan" means Blue Cross Blue Shield of Montana. See Chapter 9 of the Summary Plan Document for definitions of other terms.

EFFECTIVE JANUARY, 2004

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CHAPTER 2
HOW TO OBTAIN BENEFITS

Payment of benefits by the State Plan will be made on the basis of your submission of required information to the Blue Cross Blue Shield of Montana Health Plan.

ALTERNATE SECTION G. OBTAINING BCBSMT MANAGED CARE HEALTH PLAN BENEFITS

G.1 Steps to Take in Advance of Receiving Services

1. Make sure you have a current identification card from the health plan. Make sure it contains the correct identification number, name(s), dependent coverage information, and date(s) of birth. If you need services before you receive your card or have lost it, ask your provider to verify your coverage by calling the health plan or the Employee Benefits Bureau (EBB). Replacement cards can also be ordered by calling the health plan.

2. Make sure there is an available BCBSMT network (in-network) Personal Care Provider (PCP) in your area that you and any enrolled dependents feel comfortable using for your typical health care needs, and for referral to a specialist, if needed. Each plan member must select and maintain a PCP, but may change PCPs under some circumstances by contacting the health plan. You may also want to determine if there are specialists in the BCBSMT network that will meet your (and member dependents') medical needs.

A list of BCBSMT PCPs is distributed with annual change period materials. For a full list of in-network providers and updates to the PCP list, see the BCBSMT web site at www.bluecrossmontana.com. The BCBSMT web site allows you to search for network providers statewide or in your area for the managed care benefit plan administered by BCBSMT and referred to as the "State of Montana HMO."

You may also identify participating (BCBSMT member) providers. These are providers on the "Blue Cross and Blue Shield of Montana" list, but not on the "State of Montana HMO" list. These participating (BCBSMT member) providers are not recognized as in-network providers (to whom you may self-refer and obtain the in-network level of benefits), but they have agreed to accept allowable fees as payment in full, and thus will not balance bill State Plan members for charges in excess of these fees.

3. In advance of receiving non-emergency services, know and optimize your benefits:

   a. Obtain pre-certification for inpatient hospital stays. All non-emergency inpatient hospital stays should be certified prior to admission by calling the health plan to make sure the stay meets medical necessity requirements for inpatient benefits. All emergency admissions should be certified within 24 hours after admission, or at the first opportunity, to make sure any continued stay meets medical necessity criteria for inpatient benefits. The hospital will typically make this call to assure payment, but since you are responsible for any charges that are not benefits of the managed care plan, you may want to call for your own protection. Pre-certification is especially critical for any inpatient facility admissions/stays for: organ transplants, treatment of mental illness or chemical dependency, and rehabilitation therapy or recovery, as indicated in Chapter 3.

   b. Determine if you need prior authorization by the health plan for specific proposed medical procedures, equipment, or supplies. You must call the health plan and obtain prior authorization to receive benefits for:

      1) durable medical equipment expenses in excess of $500;
      2) infertility treatment; and
      3) obesity treatment (nonsurgical).

   c. Services for which prior authorization is **recommended** include, but are not limited to (a

retrospective review will be done if services are not prior authorized):

1) cardiac and/or pulmonary therapy;
2) chronic pain programs
3) dietary and nutritional counseling
4) home health services
5) hospice
6) inpatient hospital and provider care
7) Magnetic Resonance Imagining (MRI), Computed Axis Tomography (CAT scan, CT scan), and Positron Emission Tomography (PET Scans)
8) reconstructive surgery
9) TMJ surgery
10) transplants

Call and obtain prior authorization for any services that are new or outside standard medical practice (and which may be excluded as experimental), or that are only covered under some circumstances (as described in Chapter 3) to assure coverage.

d. Obtain the in-network level of benefits (the highest level of benefits and described in the current Annual Change or New Employee Booklets) by:

   1) obtaining covered services from a BCBSMT network provider listed on the BCBSMT web site for the "State of Montana HMO;" or
   2) obtaining covered services from an out-of-network provider under the following circumstances:

      a) With a referral from your PCP (or designated stand-in physician or mid-level practitioner), and in the case of admission to an out-of-network hospital, pre-certification by the health plan. Referrals to out-of-network providers are generally only made when circumstances preclude in-network services.

      b) For treatment of an emergency medical condition. In the case of a medical emergency, plan members are encouraged to obtain services from the closest appropriate provider. You will receive the in-network level of benefits for immediate treatment of an emergency medical condition by any covered provider, including an out-of-network provider. However, you will only receive the in-network level of benefits for any out-of-network follow up care (after the medical emergency has ended) if the above referral and pre-certification requirements are met.

   Care received from a provider other than a BCBSMT network provider will be covered at the out-of-network level of benefits (also described in the current Annual Change or New Employee Booklets).

   It is always advisable to obtain a written referral from your PCP for non-emergent or non-urgent care services to either an in-network specialist or an in-network provider — including a participating (BCBSMT member) provider.

c. Determine if there are frequency, duration, or dollar limits on services you plan to receive so you can consider alternatives if needed (see Section L and the current Annual Change or New Employee Booklets).

d. If you must use an out-of-network provider without PCP referral, try to use a participating (BCBSMT member) provider. This will protect you against charges in excess of the health plan's allowable fee. You are responsible for paying these charges (in addition to any deductible, coinsurance, or copayment for the out-of-network level of benefits), unless the provider has agreed to accept the allowable fee as full payment. Note the medical services identified in L.1 that are not available as an out-of-network benefit. See G. 1 for instructions on identifying BCBSMT member providers.

G.2 Steps to Take to Receive Benefits and Payment

1. Present your identification card to the physician, hospital, or other health care provider when you or any covered dependents receive services, and pay any required copayments.
2. Make sure the provider has your current identification number and address. If you change your address, notify the EBB.

3. You may need to complete a standard claim form if you use a provider who is neither an in-network provider, nor a participating (BCBSMT member) provider. A standard claim form should be available from the provider. Have the provider complete his/her portion, and send the completed form, with all itemized bills attached, to the health plan at the address on your identification card.

4. Payment will automatically be sent directly to BCBSMT network providers and participating (BCBSMT member) providers who have agreed to accept allowable fees, as well as to out-of-network providers whose bills include an assignment of benefits from you. You will receive payment directly for services for which no assignment of benefits has been made. For both in-network and participating (BCBSMT member) providers, you will be responsible for paying the deductible, coinsurance, copayment, and non-covered service charges only — not amounts above the allowable fees.

5. Respond to requests for information about accidents, other insurance coverage, or any other information requests from the health plan. Your claim will not be paid until the required information is received.

CLAIMS FILING DEADLINE

Claims must be filed within one year from the date the expenses were first incurred to receive benefits, unless you show that it was not reasonably possible to file a claim within this time limit.

EXPLANATION OF BENEFITS (EOB)

Check EOBs from the health plan to determine if you have received the benefits described in this Managed Care Plan Supplement, and to determine what fees you owe the provider (any deductible, copayments not paid at the time of service, coinsurance, charges for uncovered services, and charges in excess of allowable fees when using providers who are not BCBSMT network or participating [BCBSMT member] providers).

G.3 CLAIMS ASSISTANCE

If you need assistance with a claim or an explanation of how a claim was paid, call BCBSMT at the customer service number on your identification card. If you are not satisfied with the plan's explanation of a denial or partial denial of benefits, you may file an appeal as described in Section J of the Summary Plan Document.

CHAPTER 3
MEDICAL BENEFITS

ALTERNATE SECTION L. MANAGED CARE BENEFITS ADMINISTERED BY BLUE CROSS BLUE SHIELD OF MONTANA

L.1 Covered Medical Expenses and Services

1. COVERED MEDICAL EXPENSES

Covered medical expenses of the managed care plan administered by Blue Cross Blue Shield of Montana are:

a. expenses within allowable fees; you are responsible for amounts over allowable fees if you use a provider other than a BCBSMT network provider or a participating (BCBSMT member) provider;
b. expenses within the specified benefit limitations contained in this chapter and the current Annual Change or New Employee booklets, and which meet other requirements of the Summary Plan Document; and
c. expenses for covered medical services, defined next.

2. COVERED MEDICAL SERVICES

Covered medical services are services, procedures, and supplies:

a. listed in this section as covered medical services, and not excluded in L.29;
b. determined by the health plan to be medically necessary for the diagnosis or treatment of:
    1) injury;
    2) illness;
    3) maternity care; or
    4) are preventive services specified in this section.
c. provided to a member by a covered provider; and
d. provided and coded in accordance with applicable medical policy.

3. IN-NETWORK LEVEL OF BENEFITS

You receive the in-network level of benefits (described in the current Annual Change or New Employee Booklets) for covered medical services that are:

a. services provided by an in-network provider;
b. treatment of an emergency medical condition (by any provider);
c. other out-of-network care with prior referral by your BCBSMT PCP (or designated stand-in physician or mid-level practitioner), and in the case of admission to an out-of-network hospital, pre-certification by the health plan.

You will be responsible for any copayment, deductible, and coinsurance amounts specified for the in-network level of benefits in the current Annual Change or New Employee Booklets. See L.2 and L.28 for any special requirements for receiving the in-network level of benefits for particular covered medical services or services with limited coverage.

4. OUT-OF-NETWORK LEVEL OF BENEFITS

You will receive the reduced out-of-network level of benefits (also described in the current Annual Change or New Employee Booklets) for all other covered medical services with some exceptions. There are no benefits for the following services unless you have a referral from your PCP to pay under in-network level of benefits. (see L.1, provision 3):

a. chiropractic services;
b. organ transplant services;
c. educational services;
d. infertility treatment; and
e. obesity treatment (nonsurgical).

For covered medical services eligible for the out-of-network level of benefits, you will be responsible for any applicable copayment, deductible, and coinsurance amounts described in the current Annual Change or New Employee Booklets. You will also be responsible for any charges in excess of the health plan's allowable fee by non-participating providers who do not accept

the plan's allowable fees as full compensation as well as any applicable out-of-network differential.

L.2 Covered Medical Services

The State Plan covers the health care services listed in sections L.3 - L.28 (and not excluded in L.29) when they meet the other requirements for covered medical services described in L.1. These covered medical services are eligible for either the in-network level of benefits (L.1, provision 3) or the out-of-network level of benefits (L.1, provision 4). The covered medical expenses (L.1, provision 2) for these claims are paid or credited to the member's deductible, copayment, and coinsurance obligations for the applicable level of coverage, depending on the in-network or out-of-network status of the claim. Coverage is subject to all waiting periods and other applicable provisions of the Summary Plan Document.

L.3 Inpatient Hospital Care

Pre-certification of all hospital admissions is strongly recommended.

Inpatient hospital care is covered and includes, but is not limited to: room and board; general nursing care; special diets; use of operating room and related facilities; use of intensive care units and services; x-ray, laboratory, and other diagnostic tests; drugs, medications, biologicals, anesthesia, and oxygen services; physical, radiation, and inhalation therapy; psychotherapy; administration of whole blood and blood plasma; short-term rehabilitation therapy services; and medical detoxification when the inpatient stay is certified as medically necessary by the health plan.

L.4 Inpatient Provider Care

Pre-certification of all hospital admissions is strongly recommended.

Coverage includes health care services performed, prescribed, or supervised by a covered provider including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services.

L.5 Outpatient Hospital Services

Hospital services and supplies described in L.3 are covered if a member is treated at a licensed hospital, but not admitted for bed patient care. Charges for observation beds/rooms are covered when medically necessary and in accordance with medical policy for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day.

L.6 Outpatient Office Visit Services

Coverage includes health care services provided by a physician or mid-level practitioner working in a physician's office or clinic, or by other office/clinic staff members under physician direction. This includes, but is not limited to: diagnostic, treatment, laboratory, x-ray, radiation, and referral services.

The office visit co-pay includes any lab and/or diagnostic service that is rendered and billed by the physician or clinic you are visiting in conjunction with the office visit.

L.7 Ambulance Transportation

Only emergency ground or emergency air transportation is covered to the nearest hospital or medical facility that is equipped to furnish the services, unless otherwise approved by the health plan. The emergency transportation must be medically necessary. The medical necessity is established when the patient's condition is such that other means of transportation would endanger the health of the member. Transportation is not covered if not medically necessary.

L.8 Ambulatory Surgical Center Services and Supplies

Prior authorization of non-emergency surgery is strongly recommended.

Coverage includes ambulatory surgical center or outpatient hospital services and supplies furnished in connection with a covered surgical procedure performed in the center, provided the center is licensed or certified for Medicare by the state in which it is located.

L.9 Congenital Anomaly

Coverage includes the treatment only of medically diagnosed congenital defects and birth abnormalities.

L.10 Emergency Care

Coverage includes health care for an emergency medical condition with acute symptoms that would reasonably cause a member to believe that the absence of medical attention would place the member's health in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of a bodily organ or part.

The emergency room co-payment (as identified in the current Annual Change or New Employee booklets) only includes the facility charges. Any professional charges and/or any lab or diagnostic fees are subject to deductible and coinsurance.

SPECIAL REQUIREMENT TO RECEIVE THE IN-NETWORK LEVEL OF BENEFITS FOR OUT-OF-NETWORK SERVICES

The in-network level of benefits is provided for out-of-network emergency services immediately required to diagnose and treat an emergency medical condition at the nearest appropriate medical facility without prior referral by a PCP.

If an emergency medical condition is determined to exist that requires hospital admission or any follow-up services, you must notify the health plan within 24 hours of (or the next working day after) the initial emergency care so the health plan can coordinate the subsequent follow-up care and assure continued in-network benefits. If you are incapable of calling or having a representative call the health plan within 24 hours (or on the next working day), you should contact the health plan as soon as medically possible. Once medical stabilization is achieved, BCBSMT may certify transfer to a BCBSMT network hospital for the in-network level of benefits to continue.

L.11 Dialysis

Coverage is provided for renal disease, including the equipment, training, and medical supplies required for effective home dialysis.

L.12 Home Infusion Therapy

Coverage is provided in lieu of hospitalization. Infusion therapy includes, but is not limited to: antibiotic therapy, enteral nutrition, total parenteral nutrition, pain management, and specialized disease state therapy.

L.13 Injectible Benefit

Coverage includes injectible medications administered at the provider's office or facility including, but not limited to: allergy shots, contraception, pain control, and administration of antibiotics.

Injectibles billed without an office visit are exempt from deductible and only subject to appropriate coinsurance.

L.14 Mastectomy

Coverage is provided for mastectomies due to malignancy, and as a result of disease, illness, or injury.

L.15 Reconstructive Breast Surgery

Prior authorization of non-emergency surgery is strongly recommended.

Coverage provides reconstructive surgery after a mastectomy, which resulted from disease, illness, or injury.

Coverage is provided for:

a. reconstruction of the breast on which the mastectomy was performed;
b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. prostheses and treatment of any physical complications resulting from the mastectomy, including lymphedemas.

L.16 Obstetrics and Gynecology/GYN

Coverage includes medically necessary obstetrical and gynecological services.

The global co-payment as identified in the current Annual Change or New Employee booklets include rou-

tine office visits and labs for prenatal care. One global co-payment is applied per pregnancy regardless of benefit year.

Non-routine services are applied to deductible and coinsurance.

L.17 Obstetrical Delivery Care and Services

Coverage includes hospital obstetrical delivery care and services for covered female members. Coverage allows a minimum 48-hour inpatient hospital stay for a normal delivery, and a minimum 96-hour inpatient hospital stay for a cesarean section delivery, unless otherwise agreed and deemed appropriate by the member and attending professional provider.

L.18 Routine Newborn Care

Coverage includes the initial routine care of a newborn at birth provided by a physician, standby care provided by a pediatrician at cesarean section, and hospital nursery care of newborn infants, born in the hospital while the mother is receiving inpatient care services for the delivery.

L.19 Inborn Errors of Metabolism (including PKU)

Coverage includes the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist. Treatment includes diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment including, but not limited to: clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

L.20 Oral Surgery

Prior authorization of non-emergency surgery (especially temporal mandibular joint (TMJ)-related surgery) is strongly recommended.

Coverage includes non-cosmetic surgical treatment for the excision of lesions of the oral cavity, tongue, cheek, and maxillary/mandibular fracture, or for the treatment of degenerative joint disease that is associated with rheumatoid arthritis or osteoarthritis of the TMJ. Non-surgical treatment of TMJ-related pain, dysfunction, or disease is not covered.

Orthognathic Surgery (Reconstructive Jaw Surgery)

Prior authorization is strongly recommended.

Coverage is provided only for the treatment of congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration of the member's physical condition because of inadequate nutrition.

Dental appliances, splints, orthodontia, or other services associated with an approved jaw surgery are considered dental services and are not covered under the medical benefit.

L.21 Adult Preventive Services

1. Coverage includes an age and gender appropriate annual routine physical examination including the following periodic tests and services:
   a. routine gynecological exam, Pap test, and related lab charges;
   b. colonoscopy, proctoscopies, sigmoidoscopies, or hemocults;
   c. immunoassay for tumor antigen or prostate specific antigen (PSA); and
   d. routine diagnostic x-ray and laboratory services including chemistry screens, bone density scans, cholesterol and other blood fats tests, and the T4 thyroid test.
2. Adult immunizations recommended by the Centers for Disease Control Immunization Guidelines, excluding immunizations recommended because of increased risk due to type of employment or travel, such as, but not limited to: malaria, yellow fever, hepatitis B, and tuberculosis.

   Immunizations billed without an office visit are exempt from deductible and only subject to appropriate coinsurance.

3. Periodic routine mammograms, defined as:
   a. one baseline mammogram for women ages 35-39;
   b. one mammogram every two years for women ages 40-49 (or more frequently if recommended by the woman's physician); and
   c. one mammogram each year for women after age 50.

L.22 Reconstructive Surgery

Prior authorization of non-emergency surgery is strongly recommended.

Coverage is provided in order to restore bodily function or correct deformity resulting from a disease, trauma, or congenital or developmental abnormality. Coverage includes any consequences or complications that may arise from a covered surgery or related service.

L.23 Respiratory Therapy – Outpatient

Prior authorization is strongly recommended. Subject to visit maximum as outlined in the current Annual Change and New Employee booklets.

Coverage is provided in lieu of hospitalization for members whose medical condition requires respiratory therapy.

L.24 Severe Mental Illness

Pre-certification of all hospital admissions is strongly recommended.

Coverage includes medically necessary care and treatment of severe mental illness as defined in 33-22-706, MCA:

1. Schizophrenia.
2. Schizo-affective disorder.
3. Bipolar disorder.
4. Major depression.
5. Panic disorder.
6. Obsessive-compulsive disorder.
7. Austism.

L.25 Urgent Care

Coverage includes care for an acute illness or injury which requires immediate treatment (such as high fever; ear, nose, and throat infections; and minor sprains and lacerations) as defined in Chapter 9 of the Summary Plan Document.

The urgent care co-payment (as identified in the current Annual Change or New Employee booklets) only includes the office visit. Any lab and/or diagnostic fees are subject to deductible and coinsurance.

L.26 Well Child Benefits

1. Coverage includes well-child examinations by a physician from birth through puberty. Such exams shall include a medical history, routine physical examination, and routine developmental assessment at the following approximate ages:
   a. a physician's visit for any newborn discharged from a hospital in less than 36 hours;
   b. one month;
   c. two months;
   d. four months;
   e. six months;
   f. nine months;
   g. 12 months;
   h. 15 months;
   i. 18 months;
   j. 24 months; and
   k. once per year thereafter, until the child reaches the appropriate age for adult preventive services.
2. Laboratory tests are covered according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101, MCA.
3. Routine immunizations are covered according to the schedule of immunizations recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services.

L.27 Diagnostic/Laboratory Services

Prior authorization is strongly recommended for MRIs, CT Scans, CAT Scans and PET Scans.

1. Coverage includes x-ray, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing accident or illness when hospital confinement is not required and benefits are not provided elsewhere in this Managed Care Plan Supplement.
2. X-ray and laboratory benefits shall not be provided for the following:
   a. dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident (covered under L.28.2);
   b. visual examinations (covered under Section M of the Summary Plan Document); and
   c. premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in L.21.

L.28 Services with Limited Coverage

The following are health care services and supplies that are covered as described in L.2, but with special limitations.

Some of these services have no out-of-network level of benefits, as specified next (and as listed in L.1, provision 4). They are only covered when provided by your BCBSMT PCP (or a designated stand-in physician or mid-level practitioner), or with your PCP's (or designated stand-in's) referral. Some services require prior authorization by the health plan (in advance of the service) for any benefits (either in-network or out-of-network). Some services have dollar or service limits, or require a physician's order.

1. CHEMICAL DEPENDENCY TREATMENT

Pre-certification of all hospital admissions is strongly recommended.

Coverage is provided for inpatient and outpatient treatment for alcoholism and drug addiction (excluding costs for medical detoxification, which is covered under L.3). Coverage is limited to a maximum combined benefit of $6,000 for a 12-month period, until a lifetime maximum inpatient benefit of $12,000 is met. After that, the annual benefit for inpatient and outpatient treatment of $2,000 may be available.

2. DENTAL SERVICES FOR ACCIDENTAL INJURY

Coverage is provided for the treatment of accidental dental injury only, and is limited to the restorative services and supplies necessary for the treatment of a fractured jaw or other accidental injury to sound natural teeth, provided that all of the following criteria are met:

a. the dental injury occurs while the member is enrolled in the State Plan;
b. the treatment is completed within 12 months after the date of the accidental injury.

Services for the treatment of accidental injury to teeth caused by biting or chewing are exclusions of this provision, but are covered by the Dental Plan.

3. DIETARY AND NUTRITIONAL COUNSELING

Prior authorization is strongly recommended.

Dietary and Nutritional coverage is provided when medically necessary and with a physician's referral.

4. EDUCATION PROGRAMS

No out-of-network level of benefits is available. Maximum benefit $250 per benefit year.

Coverage is provided when referred by a BCBSMT'S PCP (or designated stand-in physician or mid-level practitioner). The program must be a certified educational program administered by an in-network facility or professional provider. Covered programs/clinics include, but are not limited to: diabetes, multiple sclerosis, respiratory, polio, and cardiac clinics. Educational services are otherwise excluded.

5. DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS

Prior authorization is required for DME expenses in excess of $500. Coinsurance does not apply to annual out of pocket maximum.

Coverage is provided for medical purposes only and in lieu of hospitalization, or for therapeutic use in a member's home. Coverage includes rentals, purchases, and repairs (on purchased equipment). The health plan will be responsible for determining rental versus purchase agreements. Requests for computerized and "de-

luxe" equipment, like motor-driven wheelchairs, are reviewed on an individual basis. The health plan will have the right to decide when standard equipment is adequate. Coverage does not include maintenance, replacement due to loss, or duplication. Replacement can occur when equipment or prosthetics are no longer repairable.

DME and prosthetic items include, but are not limited to:

a. hospital beds;
b. wheelchairs or walkers;
c. foot orthotics (with a $100 per foot per year limit, and coverage is not provided for the sole purpose of treating sports-related activities);
d. breast prostheses;
e. oxygen services and supplies; and
f. prosthetic appliances. Coverage includes the purchase and fitting of artificial limbs, larynx, eyes, other prosthetic appliances, or permanent internally implanted devices that are not experimental. Repair, maintenance, replacement due to loss, and duplication are not covered. Replacement can occur when the item is no longer repairable.

6. HOME HEALTH SERVICES

Prior authorization is strongly recommended.

Coverage includes the following services and supplies furnished by a licensed home health agency for the care of a member in accordance with a physician's written home health care plan:

a. part-time or intermittent skilled care provided by a registered nurse or licensed practical/vocational nurse;
b. physical, occupational, respiratory, and infusion therapies (up to the maximum benefit for the therapies as described in other provisions of this Managed Care Plan Supplement);
c. medical supplies, prescribed medications, and lab services provided at home; and
d. part-time or intermittent home health aid services required to allow the member to be treated at home.

Home health services are limited to 30 visits per benefit year, where a day with any home health service is counted toward the maximum, and a day with more than four hours of home health services is counted as two visits.

The following services are non-covered home health services:

a. services and supplies that are not part of the home health care plan;
b. domestic or housekeeping services such as Meals on Wheels;
c. services for mental or nervous conditions;
d. transportation; and
e. disposable supplies self-administered in the home (gauze, bandages, etc.), unless covered elsewhere; and DME and prostheses, which are covered elsewhere.

7. HOSPICE SERVICES

Prior authorization is strongly recommended.

Members who are diagnosed as having a terminal illness with a life expectancy of six months or less may elect hospice care when ordered by a physician. The following hospice services are covered:

a. Facility expenses of a hospice facility, hospital, or skilled nursing facility for board, room, and other services and supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management. Expenses for a private room are covered only up to the regular daily expense for a semi-private room, unless medically necessary.

b. Hospice expenses for:
   1) Nursing care provided by a registered nurse or licensed practical nurse, and services of a home health aide;
   2) medical social services provided under the direction of a physician;
   3) psychological and dietary counseling;
   4) consultation or case management services;
   5) medically necessary physical and occupational therapy;
   6) medical supplies, drugs, and medicines prescribed by a physician; and
   7) expenses for consultant or case management services, or physical or occupational therapy, by health care providers who are not employees of the hospice — but only when the hospice retains responsibility for the care of the person.

8. INFERTILITY TREATMENT

Prior authorization is required. No out-of-network level of benefits is available.

Benefits include diagnostic and evaluation services to determine if treatment for infertility is necessary. Follow-up treatment is limited to members who have been diagnosed as biologically infertile in accordance with accepted medical practice. Artificial insemination attempts are limited to three per member per lifetime. Infertility services do not include in-vitro fertilization. Infertility services are not covered for members who have undergone a voluntary sterilization procedure.

9. MENTAL ILLNESS

Pre-certification of all hospital admissions is strongly recommended.

Coverage is provided for medically necessary inpatient and outpatient treatment of mental illness. Inpatient services are limited to a maximum of 21 days; no maximum for severe mental illness defined in 33-22-706, MCA. Please refer to current Annual Change or New Employee booklets for visit limits; no maximum for severe mental illness as defined in 33-22-706, MCA. Covered services do not include the treatment of the following conditions:

a. developmental and learning disorders;
b. speech disorders;
c. psychoactive substance abuse disorders;
d. eating disorders (except bulimia and anorexia nervosa);
e. impulse control disorders (except intermittent explosive disorder and trichotillomania);
f. mental retardation; or
g. inpatient confinement for environmental change.

10. CHIROPRACTIC SERVICES

No out-of-network level of benefits is available. Please refer to the current Annual Change or New Employee booklets for visit limitations.

11. OBESITY MANAGEMENT

Prior authorization is required for benefits. No out-of-network level of benefits is available.

Coverage includes non-surgical treatment for reducing or controlling weight under a prior-authorized treatment plan. The member must meet the definition of morbid obesity in Chapter 9 of the Summary Plan Document, and make timely progressive weight loss for benefit continuation. Bariatric and other surgeries to reduce weight, dietary supplements, and exercise programs are not included in this benefit.

12. REHABILITATIVE THERAPY

Prior authorization is strongly recommended. Please refer to the current Annual Change or New Employee booklets for inpatient and outpatient maximums.

Coverage includes services such as physical, occupational, cardiac, pulmonary, and speech therapy that are ordered by a covered physician. For therapies to be eligible for coverage, the member must meet one or more of the following criteria:

a. has suffered an acute injury or serious illness which debilitates muscles or speech, or hinders the activities of daily living; or
b. is receiving treatment for medically diagnosed congenital defects or birth abnormalities; or
c. is suffering an exacerbation of an illness/injury, causing further debilitation

13. ORGAN TRANSPLANTS

Benefits are only available through the designated transplant network. Prior authorization of outpatient services and pre-certification of the hospital stay is strongly recommended.

The health plan has designated certain hospitals to perform covered transplants. These hospitals have been selected for their experience in performing transplants and no benefits are available from other hospitals (except under rare circumstances approved in advance by the health plan). In some instances, the designated hospital may not be located in the plan's service area, therefore requiring travel. Contact the health plan for a list of designated organ transplant facilities. Covered transplant services and supplies (defined next) for all covered transplant procedures are limited to a $500,000 lifetime maximum, with $5,000 of this maximum applicable to travel to and from the facility.

a. Covered Transplant Services

Coverage includes the following services for covered transplants:

1) evaluation;
2) pre-transplant care;
3) transplant and any donor-covered services; and
4) follow-up treatment.

b. Covered Transplants

The following human organ/tissue transplants are covered:

- corneal
- heart
- heart/lung
- kidney
- liver
- lung
- pancreas

Bone marrow transplants are covered, when medically necessary, under the following circumstances:

1) Allogenic and Syngeneic Bone Marrow Transplants (Requires HLA Typing Match on at Least Five Out of Six Loci)

- acute lymphocytic leukemia and non-acute lymphocytic leukemia
- chronic melogenous leukemia
- aplastic anemia
- Franconi's Anemia
- infantile malignant osteopertrosis
- large-cell lymphoma
- lymphoma
- Severe Combined Immudeficiency Disease (SCIDS)
- Wiscott Aldrich Syndrome

2) Autologous Bone Marrow Transplants

- acute lymphocytic leukemia and non-acute lymphocytic
- leukemia
- Burkitts Lymphoma
- large-cell lymphoma
- non-Hodgkin's lymphoma
- Hodgkin's Disease
- neuroblastoma

c. Donor Benefits

Donor services and supplies will not be covered if provided to an enrolled donor when the recipient is not enrolled under the health plan or is not eligible for transplant benefits. The exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.

d. No Coverage for the Following:

1) Services or expenses related to the transplantation of animal or artificial organs.

2) Transplants that are not currently approved under Medicare transplant guidelines.

3) Charges that are not routinely made to all patients receiving similar human organ transplants.

4) Benefits for a human organ transplant donor who has coverage elsewhere. If the donor does not have coverage elsewhere, and the recipient is a member, then the donor will be covered under this health plan, but only for health services related to the organ donation.

5) Kidney transplants that are first covered by Medicare.

6) Experimental or investigational procedures.

14. SKILLED NURSING FACILITY CARE

Please refer to the current Annual Change or New Employee booklets for benefit maximum.

Coverage is provided for medically necessary care by a licensed institution, or part of an institution that offers skilled nursing services (as defined in Chapter 9 of the Summary Plan Document).

L.29 Health Plan Exclusions

The following exclusions are considered non-covered health care services and supplies:

1. NON-COVERED SERVICES

Exclusions include health care services and supplies that are not listed as covered services even if provided by a covered provider.

2. SERVICES WHICH ARE NOT MEDICALLY NECESSARY

3. NON-AUTHORIZED SERVICES

Exclusions include services not performed, arranged, authorized, or approved as specified in this Managed Care Plan Supplement.

4. PRESCRIPTION DRUGS

Exclusions include prescription drugs, which are covered by a separate Prescription Drug Plan (see Section K of the Summary Plan Document).

5. PRE-EXISTING CONDITIONS

Pre-existing conditions are excluded for up to one year from a member's coverage. However, the period of exclusion may be reduced by creditable coverage as described in C.6 of the Summary Plan Document. The EBB will assist the member in determining if they are entitled to any reduction in the pre-existing condition exclusion period.

6. HEARING AID SERVICES

Exclusions include all services and supplies related to the purchase, examination, or fitting of hearing aids; supplies; and tinnitus maskers.

7. COMPLICATIONS FROM INELIGIBLE PROCEDURE

Exclusions include surgery and other services and supplies related to (or required to treat) complications arising from any procedure ineligible for coverage under this Managed Care Plan Supplement.

8. ELECTIVE, COSMETIC, AND VOLUNTARY HEALTH SERVICES

Except as specifically provided in this Managed Care Plan Supplement, exclusions include all services related to voluntary personal health improvement, cosmetic, or other elective health care including, but not limited to:

a. Surgery and any related services for the sole intent to improve appearance.

b. Services and supplies for cosmetic purposes, including the restoration of hair and appearance of skin, and/or body shape.

c. Personal hygiene and convenience items including, but not limited to: air conditioners, humidifiers, or physical fitness equipment.

d. Lifestyle improvements, such as physical fitness programs.

e. Services and/or memberships provided through facilities including, but not limited to: health clubs, fitness centers, or spas.

f. Dietary regimen supplements and/or exercise programs for the controlling or reduction of weight, except the limited obesity treatment benefit (described in L.28, provision 11).

g. Dietary supplements, except medical foods required for the treatment of inborn errors of metabolism (described in L.19).

h. Procedures, services, drugs, and supplies related to elective abortions, except when the pregnancy is the result of an act of rape or incest.

i. Treatment leading to (or in connection with) sexual reassignment including, but not limited to: surgery and mental health counseling.

j. Services and supplies for (or related to) conception by artificial means, except as provided in L.28, provision 8.

k. Services and supplies needed to reverse a sterilization procedure, including tubal ligations and vasectomies.

l. Treatment of non-organic sexual dysfunction.

m. Pastoral, financial, or legal counseling.

n. Counseling services for adolescent behavior problems, learning delays, self discovery and improvement, and family and marital problems, except as provided by the Employee Assistance Program (see Section M of the Summary Plan Document).

o. All services related to routine, non-medically necessary foot care including, but not limited to: the treatment or removal of corns, calluses, or nails; hypertrophy; hyperplasia of skin or subcutaneous tissues; cutting or trimming of nails; treatment of weak, strained, or flat feet; fallen arches; orthotic appliances, lifts, and orthopedic shoes (except the foot orthotic benefit provided in L.28, provision 5); padding and strapping; and fabrication.

p. Physical examinations and other services required for obtaining or maintaining employment, insurance, or government licensing, unless they are a portion of an annual physical assessment covered as a preventive service (as defined in L.21 or L.26).

q. School, sports, and camp physicals, unless they are part of an annual physical assessment covered as a preventive service (as defined in L.21 or L.26).

r. Over-the-counter supplies including, but not limited to: bandages, splints, and medications.

s. Any device for the sole purpose of enhancing sports-related activities.

t. Immunizations for foreign travel.

u. Education or tutoring services, except as provided in L.28, provision 4.

9. NURSING HOME AND RELATED CONVALESCENT CARE

Except as specifically provided in this Managed Care Plan Supplement, exclusions include:

a. Confinement in a skilled nursing facility or convalescent hospital, or that part of such facility used for:
   1) convalescent, custodial, or rest care;
   2) mental illness or chemical dependency care; or
   3) training, or schooling.

b. Services or articles for custodial, convalescent, or maintenance care; domiciliary care; rest care; or care designed primarily to assist in the activities of daily living.

c. Long-term care services.

10. EXPERIMENTAL PROCEDURES

Exclusions include experimental procedures (as defined in Chapter 9 of the Summary Plan Document) and/or medical treatments, procedures, drugs, devices, or biologics that are experimental, investigational, or used for research.

11. NON-STANDARD OR SELF-PRESCRIBED SERVICES AND SUPPLIES

Except as specifically provided in this Managed Care Plan Supplement, plan exclusions include all services for non-standard, or self-prescribed therapies including, but not limited to:

a. orthomolecular therapy, including nutrients, vitamins, and food supplements;
b. hypnotism, hypnotherapy, or hypnotic anesthesia;
c. acupuncture or acupressure;
d. stress management;
e. biofeedback;
f. naturopathy;
g. homeopathy;
h. chelation therapy (except for mineral or metal poisoning);
i. massage or massage therapy; and
j. rolfing.

12. INJURY OR SICKNESS RELATED TO ILLEGAL ACTIVITIES

Exclusions include the care and treatment of injuries or sickness due to the commission of (or attempt to commit) a felony act, or engaging in an illegal act or occupation.

13. INJURY OR SICKNESS RELATED TO A RIOT

Exclusions include the care and treatment of injuries or sickness due to voluntary participation in a riot.

14. LEGALLY-ORDERED SERVICES

Exclusions include services which are not deemed medically necessary regardless of whether required by a court order, or as a condition of parole or probation.

15. ADMINISTRATIVE CHARGES

Exclusions include the charges for missed appointments or other administrative sanctions.

16. INJURIES OR SICKNESS RELATED TO MILITARY SERVICE

Exclusions include services for (or related to) any sickness or injury suffered as a result of (or while in) military service.

17. SERVICES INCURRED OUTSIDE THE COVERAGE PERIOD

Exclusions include services incurred outside the coverage period, including:

a. while the member is not covered;
b. prior to the effective date of coverage for a member; and
c. after a member's termination of coverage, and after any extension of benefits or continuation of coverage, as specified in this contract.

18. TRAVEL

Travel is excluded, except transportation of the patient in an emergency to the nearest facility qualified to treat the injury or disease, or as otherwise provided in the ambulance benefit (L.7) or the transplant benefit (L.28, provision 13) and approved by the health plan.

19. CERTAIN PRIVATE ROOM CHARGES

Exclusions include private room accommodations to the extent charges are in excess of the institution's most common semi-private room charge, unless a private room is deemed medically necessary by the plan.

20. DUPLICATE SERVICES OR SERVICES COVERED UNDER ANOTHER BENEFIT PLAN

Except as specifically provided in this Managed Care Plan Supplement, and subject to the Coordination of Benefits Section (Chapter 7 of the Summary Plan Document), all services covered by another benefit plan are excluded including, but not limited to:

a. Government-Covered Services and Supplies

Exclusions include services and supplies to the extent they are covered by any governmental law, regulation, or program (such as Medicare, Medicaid, and Champus), subject to federal and state laws or regulations.

Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your State Plan. When such a circumstance occurs, you will receive an EOB.

b. Workers' Compensation-Covered Services

Exclusions include services for injuries or diseases for which benefits are (or should be) provided pursuant to state workers' compensation laws.

This exclusion applies to all services and supplies provided to treat such illness or injury even though:

1) Coverage under the government legislation provided benefits for only a portion of the services incurred.

2) Your employer failed to obtain such coverage as required by law. This exclusion does not apply if your employer was not required and did not elect to be covered under any workers' compensation law, occupational disease law, or employer's liability act of any state, country, or the United States.

3) The member waived his or her rights to such coverage or benefits.

4) The member failed to file a claim within the filing period allowed by law for such benefits.

5) The member failed to comply with any other provision of the law to obtain such coverage or benefits.

6) The member was permitted to elect not to be covered by the workers' compensation law, but failed to properly make such election effective. This exclusion does not apply if you are permitted by statute not to be covered and you elect not to be covered by a workers' compensation law, occupational disease law, or liability law.

If the member enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, this contract will not cover past or future medical services that are the subject of (or related to) that settlement. In addition, if the member is covered by a workers' compensation program that limits benefits if providers other than those specified are used, and the member receives care or services from a provider not specified by the program, this contract will not cover the balance of any costs remaining after the program has paid.

c. Expenses Covered by Other Insurance Policies

Exclusions include expenses that a member is entitled to have covered (or that are paid) under an automobile insurance policy, a premise liability policy, or other liability insurance policy (such as a home owners or business liability policy). Exclusions also include expenses the member would be entitled to have covered under such policies if not covered by the State Plan, unless applicable law requires the health plan to provide primary coverage.

21. CHARGES MEMBERS ARE NOT OBLIGATED TO PAY

Exclusions include services and supplies for which a member is not legally, or as a customary practice, required to pay in the absence of insurance or a hospital medical payment plan.

22. THIRD PARTY LIABILITY

Exclusions include services and supplies when another person or entity is legally responsible for causing or contributing to the condition which is being treated, and is therefore liable at law for the cost of treatment, except as provided in the subrogation provisions of Chapter 7 of the Summary Plan Document.

23. UNUSUAL CIRCUMSTANCES

Neither the health plan nor any in-network providers shall have any liability or obligation because of a delay or failure to provide covered services or benefits under the following circumstances:

a. complete or partial destruction of facilities;
b. war;
c. riot;
d. civil insurrection;
e. major disaster;
f. disability of a significant part of the participating hospital and/or provider network;
g. epidemic; or
h. labor dispute not involving the health plan, participating hospitals, and/or other participating providers.

In-network providers will make their best efforts to provide services and benefits within the limitations of available facilities and personnel. If the rendering of covered services or benefits is delayed due to a labor dispute involving the health plan or participating providers, non-emergency care may be deferred until after the resolution of the labor dispute.

24. VOCATIONAL REHABILITATION

25. DENTAL COVERAGE

Exclusions include dental coverage (see L.28, provision 2, for limited coverage due to accidental injury).

26. VISION SERVICES AND APPLIANCES

Exclusions include vision services and appliances including eye exams, glasses, contact lenses, radial keratomy or other surgery to correct vision, and orthoptic or vision training (see Section M of the Summary Plan Document for information on separate Optional Vision Insurance).

27. TREATMENT FOR MALOCCLUSION OF THE JAW

Exclusions include services for temporomandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements, myofascial pain syndrome, and orthodontics (dentofacial orthopedics) or related appliances. Surgical treatment for these conditions will be allowed only if prior authorized by the health plan.

28. ORGAN OR TISSUE TRANSPLANTS

Organ and tissue transplants are excluded, except as provided in L.28, provision 13.

29. ANY ADDITIONAL CHARGES FOR INCLUSIVE PROCEDURES OR SERVICES

Exclusions include additional charges for inclusive procedures or services (as defined in Chapter 9 of the Summary Plan Document, and as determined by the health plan).

30. SERVICES OR SUPPLIES NOT PROVIDED BY A COVERED PROVIDER OR WHICH ARE NOT LISTED AS A BENEFIT IN THIS SUMMARY PLAN DOCUMENT.

PRODUCED BY THE
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